U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

AHRQ

QUALITY AND PATIENT SAFETY: WHOSE RESPONSIBILITY IS IT ANYWAY?

An Invitational Workshop

AHRQ Conference Center
November 8-9, 2004
Rockville, MD

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EXECUTIVE SUMMARY

BACKGROUND

The U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG) recommended that the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) convene a conference to discuss quality improvement issues in Managed Care Organizations (MCOs) and physician practice groups.

The impetus for this conference emanated from a charge of the OIG, as stated in a May 2001 report entitled "*Managed Care Organization Non-reporting to the National Practitioner Data Bank: A Signal for Broader Concern*[1]." The report addressed under-reporting by MCOs to the National Practitioner Data Bank (NPDB) and the limitations of hospitals, physician practice groups, and State licensing boards ("downstream entities") that MCOs increasingly relied upon to protect patients from poorly performing practitioners. The OIG report cited the 2000 Institute of Medicine (IOM) report: "*To Err is Human: Building a Safer Health System."* Specifically, it cited the IOM report's emphasis on error-prone systems and its acknowledgment that adequate systems must also exist to identify and deal with poorly performing practitioners.

Within HHS, AHRQ serves as the focal point for promoting patient safety and HRSA, through its Center for Quality and the NPDB, has an implicit goal of protecting the public from harm. The OIG recommended a joint conference involving these two agencies because it "could contribute significantly to understandings about the clinical oversight being undertaken in managed care settings."

ORIGINAL WORKSHOP GOAL

The workshop goal was to develop consensus on the topic: "Quality and Patient Safety in Managed Care Organizations: Whose Responsibility is it Anyway?"

PARTICIPANTS

Fourteen national health care experts were selected to participate in this workshop. The participants are listed in Appendix D.

SUMMARY OF THE PROCESS

In preparation for the workshop, the Delphi decision-making process was used to develop consensus on the answer to the question "Quality and Patient Safety in Managed Care Organizations: Whose Responsibility is it Anyway?" from an ideal perspective. The stages of the Delphi decision-making process are: developing

[1] Available at http:oig.hhs.gov/oei under Office of Inspection and Evaluation Reports

working statements; categorizing and rating the statements; and re-rating the statements after reviewing other participants' ratings and rationale. Because the process was conducted by mail, it allowed for a degree of anonymity, which guards against participants' reputations influencing the outcomes.

The statements, ratings and rationale from the Delphi method were provided to workshop participants in advance of the workshop. During the workshop, the focus shifted from the "ideal" perspective to a "real-world perspective" and the nominal group process was employed. The stages of the nominal group process are: silent development of items; sharing items and eliminating duplication; advocating and discussing items; and prioritizing items by voting.

At the onset of the workgroup, participants revised the goal from a limited focus on MCOs to the broader question of "Quality and Patient Safety: Whose Responsibility Is It Anyway?" Their rationale was that MCOs do not operate in a vacuum. In addition, the OIG report cited a concern that MCOs are relying on hospitals, physician practice groups and State licensing boards to identify and deal with poorly performing practitioners. The report questioned how well these downstream entities protect patients from those few practitioners who can be dangerous. Quality and patient safety is a responsibility of MCOs, as well as these downstream entities and other health care stakeholders.

The participants identified the stakeholders in quality and patient safety as: government and regulations; accreditation and certification organizations; purchasers (private and public); economics/plans (defined as covered lives); professionalism; health care delivery institutions/systems; and consumers. The participants also determined that recommendations should be achievable within four years. After the participants reached consensus on recommendations for each category of responsibility, a crosswalk of the recommendations was developed between categories.

MAJOR RECOMMENDATIONS

The top five recommendations for each category (in priority order) resulting from the prioritization are as follows. A complete list of statements appears in Appendix A.

I. Government and Regulations

1. The Federal government should facilitate and fund the development of a framework, taxonomy and measurement tools for quality and patient safety.
2. The Federal government should adequately fund the development of uniform electronic health records and claims systems, including setting standards and proposing an implementation timeline with interoperability.
3. As more States set up safety related reporting systems (mandatory and

voluntary), Federal government should develop national standards governing the reporting of information; create a Federal repository for the data; guarantee a safe harbor for practitioners reporting data; and make the data publicly available.
4. State governments should incorporate continued competence mandates into State licensing requirements.
5. The Federal government should support research to develop and improve quality and patient safety management tools available to organizations.

II. Accreditation and Certification Organizations

1. Accreditation should be expanded outside health care entities to the places where health care is delivered (e.g., ambulatory centers, physician practice groups) and serve as a powerful driver that is tied to reimbursement.
2. Licensing and certification agencies should collaborate on standards that satisfy both licensing and certification requirements to ensure all practitioners are consistently credentialed in core competencies (e.g., communication skills).
3. Best practice models should be developed for accrediting and certifying organizations relative to quality and patient safety, including a system to evaluate and improve both voluntary and mandatory reporting and research to continually improve quality and patient safety tools.
4. Accreditation and certification organizations should involve patients and consumer groups in their processes and oversight. The majority of the voting members on governance bodies of accreditation and certification organizations should not represent organizations or individuals that are the objects of the accreditation or certification.
5. Accreditation and certification organizations should work with all stakeholders to reduce the burden of redundant reporting.

III. Purchasers (Private and Public)

1. Purchasers should encourage and reward consumers for improvement in self-care.
2. Purchasers should explicitly use their purchasing power to raise the quality and patient safety bar; request proposals from and contract with select health plans who agree to publicly release provider measures; and base payment on performance.
3. Purchasers should empower employees to assist in health care purchasing. If a purchaser cannot afford to award contracts on the basis of quality, the purchaser should notify its employees of the criteria used in making its choices.
4. Purchasers should educate employees to become wise consumers, and should create and use a taxonomy that designates quality and safety in educational tools.
5. Purchasers should ensure that payments to practitioners and providers include the cost of quality and patient safety reporting.

IV. Economics/Plans (Defined as entities with covered lives)

1. Health plans/insurers should fund the implementation of an infrastructure that facilitates an integrated data collection and feedback system (including practitioner, performance, quality, and safety data) using standardized information technology tools within and across plans.
2. Health plans/insurers should be held equally accountable with practitioners and providers and collaboratively work with downstream[2] entities to establish and enforce evidence-based quality and patient safety standards, policies, and programs.
3. Health plans/insurers should contract with practitioners, providers, and suppliers with a proven record of quality and patient safety.
4. Health plans/insurers should use and publicly report national measures of quality and patient safety.
5. Health plans/insurers should partner with patient quality and safety and physician organizations to develop a practitioner quality and safety measurement process.

V. Professionalism
(Six items appear since two items were rated identically.)

1. Professional organizations and practitioners should advocate for the creation of a quality and patient safety certification for practitioners that: (1) requires mastery of evidence-based medicine (if passing an examination is part of the certification process, the examination should demonstrate an understanding of and the ability to use quality and patient safety data for improvement); (2) holds the practitioner accountable for lifelong learning to maintain competence and enhance professional development; and (3) requires periodic demonstration, throughout the practitioner's career, of competence in his/her specialty, knowledge and appropriate implementation of new technologies or procedures, and communication skills.
2. Practitioners should focus on and adopt strategies for patient-centered health care delivery, which include identifying risks, both active and latent, across the continuum of care (e.g., handoffs and coordinating care with others).
3. Practitioners should: (1) communicate with patients at the appropriate health literacy level on quality and patient safety-related issues; (2) educate patients about wellness and self-care, and acknowledge their efforts to improve behavior; and (3) obtain patient-centered informed consent that discloses condition-specific risks, unanticipated adverse outcomes, and best practices; (4) maintain this data in a centralized quality and patient safety condition repository that is available to other professionals.
4. Practitioners should promote a quality and patient safety culture and

[2] Downstream entities are defined in the May 2001 OIG report entitled "Managed Care Organization Non-Reporting to the National Practitioner Data Bank: A Signal for Broader Concern" as hospitals, physician practice groups, and State licensing boards.

transparency through accountability for decisions, actions, and behavior, including meeting the intent and spirit of accreditation and regulatory quality and patient safety standards.

5. Professional organizations and practitioners should advocate for the mandatory use of compatible electronic health record systems that include clinical decision support.
6. Professional organizations should help develop, endorse, and participate in the reporting of national quality and patient safety measures.

VI. Health Care Delivery Institutions/Systems

1. Health care delivery institutions/systems that have in place formal credentialing and privileging systems should: (1) consider all areas of competency including quality and patient safety when hiring/contracting with practitioners; and (2) include processes for continuous evaluation of competencies to deliver quality and safe care.
2. Health Care Delivery institutions/systems should make "safety first" an institutional priority throughout staff, starting with leadership.
3. Health care delivery institutions/systems should participate in the development and implementation of published national standards for quality and patient safety; identify and collect valid, reliable and meaningful indicators/measures of quality and patient safety; and make available user-friendly reports of how their entities meet these standards for improvement purposes.
4. Organizations such as the American Hospital Association and the Federation of Hospitals should advocate for Federal funding for electronic health care record (EHR) systems and interconnected information technology (IT) systems.
5. Health Care delivery institutions/systems should implement inter- and intra-organizational transparent IT infrastructures to support quality and patient safety, including adequate staff training and support, and EHRs that include clinical decision support.

VII. Consumers

1. Consumers should play an active role in their health care by: (1) being allowed designate a health care advocate; (2) participating in disease self-management activities; (3) bringing potential or actual risks/errors to the attention of the appropriate person; (4) preparing for visits, asking questions, and planning for follow-up; (5) utilizing available data on quality and patient safety in making practitioner, system, and plan decisions; (6) utilizing tools for maintaining an up-to-date health history and list of current medications; and (7) disclosing to practitioner(s) conditions that could impact care (e.g., literacy and language issues and over-the-counter medications).
2. Consumers should encourage development of personal health records that are portable and accessible.

3. Consumers have a right to safe and quality health care services, and while they have responsibilities for adherence to medical recommendations, they should not be held primarily responsible for active, continual monitoring of the delivery of safe, quality services.
4. Consumers should take responsibility for their own lifestyle choices.
5. Consumers should demand government funding, development, and facilitation of a national framework for reporting quality and patient safety issues.

The major themes that cut across all categories are listed below. A complete list of statements under each category appears in Appendix B.

In order to successfully promote quality and patient safety:

1. All **stakeholders** must be involved and their ideas valued.

2. All stakeholders must be **accountable** for facilitating change from their respective areas of influence.

3. The total range of **continuity of care** must be made available. This includes making available all types of care (e.g., behavioral health care), as well as continuity of care between services and facilities.

4. New and improved **infrastructures** will need to be developed.

5. All processes must be **transparent**.

6. Specific **tools and measures** must be developed and consistently used, for example:
   6.1. **Electronic Health Records**
   6.2. **Clinical Decision-Making Support**
   6.3. **Taxonomies**
   6.4. **Reporting**
   6.5. **Centralized Data**
   6.6. **Continued Competence Requirements**
   6.7. **Consumer Education/Information**
   6.8. **Research.**

PROCEEDINGS

Welcome
Carolyn M. Clancy, M.D.
Director, Agency for Healthcare Research and Quality (AHRQ)

Dr. Clancy welcomed the participants and asked them to introduce themselves. She then explained why the timing of this meeting is important. President George W. Bush has stated his intention to spend political capital to address certain priority issues, including medical liability, during his second term. Issues of quality and safety also have been important for this administration, and much work in this area remains to be done. Dr. Clancy noted also that the timing of this meeting overlapped with a meeting that AHRQ was cosponsoring with America's Health Insurance Plans, the American Academy of Family Physicians, and the American College of Physicians on assessing quality in ambulatory care.

Dr. Clancy raised the question of how to expand quality initiatives beyond organizations that participate in voluntary accreditation and public reporting. She stressed the need to address quality issues by capitalizing on technology, both internally and externally. The public should be assured that health care organizations are doing their best to assess and improve quality and safety. However, rather than over-reporting data, there is a need to get smarter about what is being reported and to whom, because some information is more useful internally than externally. The current strategy of reporting to the public specific clinical details for selected conditions may shift toward reporting summary measures while using more detailed, science-based information internally.

What is a managed care organization (MCO) in 2004, and what is the relationship between MCOs and the professionals with whom they contract? Technology allows for the collection of information as a part of providing care, presenting a huge array of opportunities and challenges. Because the level of technology used varies among organizations, efforts to date have been based on a data scarcity model. Once clinical information systems are widely in place, an abundance of data will be available, and it will have to be used appropriately and selectively.

The question for today is: How do we improve health care quality and safety? In 2003, AHRQ released the first of what will be annual reports on the state of health care quality and health disparities in the United States (The National Healthcare Quality Report and the National Healthcare Disparities Report). The reports show that there are major opportunities for improvement in quality of care, particularly for population subgroups. With the 2004 report, useful trend data will begin to emerge.

On November 17, AHRQ, the Kaiser Family Foundation, and the Harvard School of Public Health will release a new survey on health care safety and quality that shows that public confidence in these areas is low. However, Dr. Clancy noted that individuals have an important role to play in ensuring that they get safer care. The

U.S. Department of Health and Human Services (HHS), in partnership with the American Hospital Association and the American Medical Association, has developed a list of five steps that patients can take to get safer health care:

- Ask questions if you have doubts or concerns.
- Keep and bring a list of all the medicines you take.
- Get the results of any test or procedure.
- Talk to your doctor about which hospital is best for your health needs.
- Make sure you understand what will happen if you need surgery.

Dr. Clancy stated that issues of quality and safety would remain a high priority for the Government, and that the attendees' recommendations for addressing these issues would be critical. Dr. Clancy thanked the Health Resources and Services Administration (HRSA) for its continuing partnership, and she thanked the participants for their work on this important initiative. She also expressed her eagerness to hear about the results of the meeting.

Welcome
William A. Robinson, M.D., M.P.H.
Chief Medical Officer, Health Resources and Services Administration (HRSA)

Dr. Robinson explained that Elizabeth Duke, Ph.D., administrator of HRSA, was unable to attend the meeting. He thanked Dr. Clancy for her support, and he voiced his desire to continue the longstanding collaboration between HRSA and AHRQ. He then briefly summarized HRSA's history of addressing quality in cooperation with other Federal agencies. Dr. Robinson thanked the participants for their time and expertise, and he assured them that HRSA would continue to work closely with them and others who deliver services through community health centers, the Ryan White program, and other areas.

Dr. Robinson echoed Dr. Clancy's interest in the meeting's outcomes, which he said would be disseminated throughout HRSA for the widest possible benefit. He agreed that the timing of the meeting was important, explaining that a four-year blueprint for action would dovetail with the Federal budget cycle. He also thanked the participants for bringing to the process a valuable national perspective, rather than a Federal perspective.

Dr. Robinson acknowledged that practitioners cannot function independently but instead must work within a broader health care system. Problems on both the practitioner and system levels must be addressed. Dr. Robinson again thanked the participants and assured them that the results of their work would be circulated widely.

Overview of the Delphi Process and the Nominal Group Technique
James Battles, Ph.D.
Senior Service Fellow for Patient Safety, AHRQ

Dr. Battles thanked Mr. Mark Pincus and Ms. Betsy Ranslow of HRSA and all of the participants. He noted the challenge of reaching consensus, and he reviewed the conceptual framework and principles for the task at hand.

The impetus for this work emanated from a charge of the HHS Office of Inspector General (OIG), as stated in a May 2001 report entitled "Managed Care Organization Non-reporting to the National Practitioner Data Bank: A Signal for Broader Concern." The report addressed the under-reporting by Managed Care Organizations (MCOs) to the National Practitioner Data Bank and the limitations of hospitals, physician practice groups, and State licensing boards ("downstream entities") that MCOs increasingly rely upon to protect patients from poorly performing practitioners. The OIG recommended that HRSA and AHRQ convene a conference to discuss quality improvement issues in MCOs and physician practice groups. This workshop is the response to the OIG charge.

The workshop goals are to:

- Develop consensus on the topic: Quality and Patient Safety in MCOs: Whose Responsibility is it Anyway?
- Develop real-world recommendations that can be implemented within four years. (Prior to the workshop, participants developed recommendations from an ideal perspective.)
- Produce conference proceedings reflecting the thinking of the participants.

Quality and safety are major national concerns, as highlighted in the Institute of Medicine (IOM) publications "To Err is Human" and "Crossing the Quality Chasm," as well as an article in the New England Journal of Medicine entitled "The Quality of Care Delivered to Adults in the United States" (McGlynn, 2004). Patient safety is indistinguishable from the delivery of quality care. "Crossing the Quality Chasm" cites six dimensions of quality heath care:

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

Dr. Battles defined risk as the possibility/probability of occurrence or recurrence of an event multiplied by the severity of the event, and hazard as anything that can cause harm. Threats to quality and safety are rooted in the process or structure of care rather than in underlying physiological, environmental, or disease-related antecedent conditions. According to the Donabedian model, structure plus process equals outcome. Ideally, quality and safety management can make adjustments to structure and process to minimize risks and hazards before they have an adverse impact on outcomes of care.

Dr. Battles described risks and hazards for quality and safety, which include human behaviors (active failures), process of care (organizational failures), and structure (technical failures). The challenge is to have a clear focus on identifying the sources of risk and hazards that can lead to poor outcomes of care; to "design in" quality in the structure and process of care; and to "design out" risk and hazards in the structure and process of care.

The IDEALS design concept allows participants to conceive of an ideal system and work backwards to develop a recommended system. It is more efficient and effective than to start with existing models of quality and safety and modify them to fit MCOs. Using a pyramid graphic, Dr. Battles explained Nadler's IDEALS Design Concept, which is based on a theoretical ideal system that can never be reached. The ultimate ideal system is possible to achieve, but system development and operational parameters need to be generated. In a technologically workable ideal system, technology exists and can be applied, but specific design elements must be completed. The recommended system falls between the ideal system and the present condition.

To achieve consensus thus far, the participants had used the Delphi method. First applied in the 1960s, the method has become a powerful tool to reach consensus among experts using an iterative process. The Delphi results represent the parameters of the ideal. During the workshop, the participants would move toward developing the recommended system and attempt to reach consensus on recommendations for action within 4 years. This stage would employ the nominal group technique for generating consensus. While the Delphi method allowed for a degree of anonymity, the nominal group technique is a face-to-face procedure. The stages of the technique are: silent development of items; sharing items and eliminating duplication; advocating and discussing items; and prioritizing items (voting).

These proceedings of the workshop will be submitted to the OIG and made public.

Group Reaction to the IDEAL As Represented by the Delphi Exercise
James Battles, Ph.D.

Dr. Battles reviewed the Delphi round III summary that had been distributed to the participants at the meeting, which showed the results of the previous stage of the process, and he invited questions and reactions regarding the Delphi exercise overall.

Robert Wise, M.D., Dale Austin, B.S.N., M.A., Margaret Cary, M.D., M.B.A., M.P.H., Dorothy Naylor, R.N., and Mark Netoskie, M.D., M.B.A., F.A.A.P., agreed that the process to date had been time-consuming and, at times, unclear. Dr. Battles explained that the process was intentionally vague at points to avoid limiting the responses. He asked the group to consider whether the summary accurately represented the ideal as expressed by the Delphi exercise. He noted that the nominal

group process would allow the participants to tweak what had been done previously and to add missing information.

David Swankin, Esq., stated that the summary underemphasized the key role of hospitals in quality and patient safety. He also praised the paper they had received entitled "Patient Safety and the 'Just Culture': A Primer for Health Care Executives," but he felt that it neglected the issue of incompetence, which typically accounts for about 20 percent of poor outcomes. He called for a systemic way of looking at competence and for medical education reform. Several participants voiced their agreement that incompetence must be addressed.

Dr. Wise and others discussed the fact that the participants had different perspectives on issues such as managed care and the role of the Federal Government, due to their experiences. Mr. Swankin noted that breaking the recommendations down according to components of the health care system offered advantages and disadvantages. While it allows the group to address all of the components, it fails to focus sufficiently on the interconnections among them that are so critical for success. The participants agreed that their challenge would be to make recommendations that show how to connect the components.

Several participants had questions about the extent to which they should adhere to the Delphi summary as they moved forward in the process. Dr. Battles advised the group to use the summary as a tool to move to the next level but not to be constrained by it. The participants also discussed changing their focus to an ideal care environment rather than an ideal managed care environment. Dr. Cary, Ms. Ann Carson, Dr. Wise, and Mr. Swankin noted the challenge of defining managed care, due to the fast pace of change in the industry. Mr. Swankin and Ms. Lori Bartholomew stated that health care quality is tied more closely to health care delivery than to insurance. In response to requests for clear direction on how to proceed, Dr. Battles stated that the group should focus on managed care while also identifying the other players and clarifying their responsibilities.

Dianne Zeitler, R.N., M.B.A., noted that MCOs owe it to their members to do due diligence on the providers with whom they contract to ensure that they conform to the MCO's standards and that there has not been a pattern of poor care. In indemnity plans, no one has done that due diligence. Dr. Netoskie added that the credentialing process only verifies that physicians are qualified to practice. Credentialing is a low bar that does not provide patients with the desired assurance of physician competence. Ms. Jodi Schirling agreed, adding that enrollment is based on market share rather than competency.

Dr. Wise noted that most physicians belong to at least one MCO, which makes the term managed care meaningless. Dr. Cary suggested that the group could approach the issues broadly and envision an ideal health care system. Dr. Netoskie agreed and proposed addressing managed care later, after creating an environment in which it

can work. The group agreed to remove the term managed care from their charge, to read, "Quality and Patient Safety: Whose Responsibility Is It Anyway?"

The group then moved quickly toward identifying the following components of the health care system:

1. Government and regulations
2. Accreditation and certification organizations
3. Purchasers
4. Economics/plans (defined as entities with covered lives)
5. Professionalism
6. Delivery institutions/systems
7. Consumers

Instructions for the Nominal Group Technique
James Battles, Ph.D.

Dr. Battles introduced the nominal group technique. For each component of the health care system cited above, the participants would be asked to note silently their choices for the top five actions that can be accomplished in the next four years, using the Delphi ideals as a guideline. The participants would then take turns sharing their ideas with the group, and each item would be posted on a flip chart. After all of their ideas had been recorded, the participants would group similar items. There would be an opportunity to discuss the ideas and advocate for individual items. The group would then cast ballots to prioritize the items. Finally, the results of the voting would be calculated and shared with the group.

With the IDEAL Model, What Can Be Done In the Real World in the Next 3-4 Years?—Consensus Development

The participants expanded each health care system component. As described above, the items were posted and, in some cases, reworded slightly and/or combined before voting, which established a ranking of the items. Items were ranked by participants.

Wrap-up and Adjourn

Several participants stressed the importance of common themes and interconnections among the components they had discussed. For each issue, there are prime responsibilities for some entities and secondary responsibilities for others. Dr. Battles noted that the group had agreed that quality and patient safety are a shared responsibility, with different entities having different roles to play.

Dr. Battles confirmed that the meeting report would reflect the fact that the participants had expressed their personal opinions as individuals, rather than the positions of any organization. He thanked the participants for their commitment and

hard work, and he said that he would be in touch with them as the process moved forward.

APPENDIX A

Statements Generated During the Workshop (In Rank Order)

I. GOVERNMENT AND REGULATIONS

(The top five major recommendations appear in bold.)

1. **The Federal government should facilitate and fund the development of a framework, taxonomy and measurement tools for quality and patient safety.**
2. **The Federal government should adequately fund the development of uniform electronic health records (EHR) and claims systems, including setting standards and proposing an implementation timeline with interoperability.**
3. **As more States set up safety related reporting systems (mandatory and voluntary), Federal government should develop national standards governing the reporting of information; create a Federal repository for the data; guarantee a safe harbor for practitioners reporting data; and make the data publicly available.**
4. **State governments should incorporate continued competence mandates into State licensing requirements.**
5. **The Federal government should support research to develop and improve quality and patient safety management tools available to organizations.**
6. Federal government should promulgate and enforce rules and regulations that are consistent with a just culture and contain a clear directive to address competency issues.
7. Federal and State governments should mandate that all plans offer the total range of health care coverage (e.g., including behavioral health).
8. Federal licensing statutes should encourage States to modernize licensing (See #13, below).
9. Federal government should require that pharmaceuticals and medical equipment suppliers meet all the requirements for bar coding.
10. The Federal government should massively increase in funding to the Agency for Healthcare Research and Quality for research and turning research into practice.
11. State governments should establish a minimal quality standard for practice that is self-reported and transparent.
12. State and local governments should create a uniform, user-friendly and meaningful approach to providing consumer information about quality and patient safety.
13. Federal government should create and enforce Federal licensing statutes.
14. Federal, State and local governments should promote transparency in a quality and patient safety culture.
15. Federal government should develop a structure for and fund demonstration projects for consumer groups and health care professionals to work together to improve patient safety.
16. Federal government should promote collaboration among State agencies relative to quality and patient safety.
17. Federal and State governments should, in collaboration with stakeholders, consolidate and streamline patient safety measures from key agencies and organizations.
18. Federal, State and local governments should increase the transparency of

licensing investigatory information from State to State.

19. Federal government should develop a national practitioner credentialing clearinghouse.
20. Federal government should include a broader range of practitioners (e.g., nurses, pharmacists) in the collection of data on adverse events and increase the accessibility of the data.
21. Federal government should increase the portability of patient information through the creation of a national patient health registry, which would be available to practitioners and health care entities.

II. ACCREDITATION AND CERTIFICATION ORGANIZATIONS

(The top five major recommendations appear in bold.)

1. **Accreditation should be expanded outside health care entities to the places where health care is delivered (e.g., ambulatory centers, physician practice groups) and serve as a powerful driver that is tied to reimbursement.**
2. **Licensing and certification agencies should collaborate on standards to satisfy both licensing and certification requirements to ensure all practitioners are consistently credentialed in core competencies (e.g., communication skills).**
3. **Best practice models should be developed for accrediting and certifying organizations relative to quality and patient safety, including a system to evaluate and improve both voluntary and mandatory reporting and research to continually improve quality and patient safety tools.**
4. **Accreditation and certification organizations should involve patients and consumer groups in their processes and oversight. The majority of the voting members on governance bodies of accreditation and certification organizations should not represent organizations or individuals that are the objects of the accreditation or certification.**
5. **Accreditation and certification organizations should work with all stakeholders to reduce the burden of redundant reporting.**
6. Accreditation organizations should share data with each other and the public (e.g., they should no longer allow health plans to opt out of reporting quality scores).
7. Accreditation and certification organizations should incorporate real time data elements into a system that measures continued competence (e.g., continuous reporting for electronic health records).
8. Accreditation and certification organizations should develop standards consistent with a just culture to promote non-punitive, confidential reporting of harm producing events and issues with practitioner competency.
9. Accreditation and certification organizations should collaborate on the development of common or complimentary standards relative to the measurement of quality and patient safety.

10. Accreditation and certification organizations should develop standards and measures that encourage health care entities to incorporate incentives for increasing health care quality and value.
11. Accreditation organizations should ensure that health care entities comply with the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank reporting requirements.
12. Accreditation and certification organizations should develop a national framework, taxonomy and measurement tools for quality and patient safety.
13. Accreditation and certification organizations should develop standards and measures that encourage the advancement of technology.
14. Accreditation and certification organizations should take a larger role in educating stakeholders (consumers, purchasers, etc.) about quality and patient safety.
15. Accreditation organizations should ensure that the accreditation process is a means to the end and not the end in itself.
16. Accreditation and certification organizations should assist health care entities in developing and implementing continuous compliance teams.
17. Accreditation organizations should develop processes/standards to address issues of continuity of care.
18. Accreditation and certification organizations should demonstrate the value of quality.

III. PURCHASERS (PRIVATE AND PUBLIC)

(The top five major recommendations appear in bold.)

1. **Purchasers should encourage and reward consumers for improvement in self-care.**
2. **Purchasers should explicitly use their purchasing power to raise the quality and patient safety bar; request proposals from and contract with select health plans who agree to publicly release provider measures; and base payment on performance.**
3. **Purchasers should empower employees to assist in health care purchasing. If a purchaser cannot afford to award contracts on the basis of quality, the purchaser should notify its employees of the criteria used in making choices.**
4. **Purchasers should educate employees to become wise consumers, and should create and use a taxonomy that designates quality and safety in educational tools.**
5. **Purchasers should ensure that payments include the cost of quality and patient safety reporting.**
6. Purchasers should include penalties for underperformance in the next generation of pay for performance contracts.
7. Purchasers should promote and pay for quality and patient safety sub-networks.
8. Purchasers should create a multidisciplinary study group of stakeholders to promote a collaborative approach to purchasers' and providers' common goals

for safe quality patient care.

9. Purchasers should require health plans to be accredited.
10. Purchasers should include all of the Institute of Medicine's aims, not just quality, when making purchasing decisions.
11. Purchasers should recognize the value of including providers and practitioners in the development and implementation of initiatives to improve quality and patient safety.
12. Purchasers should work with health care and stakeholder organizations to develop and disseminate information on patient safety.
13. Purchasers should provide report cards of health plans to employees and reward employees if they choose a health plan with a better track record.
14. Purchasers should provide input to the delivery of health care on new or changing quality and patient safety concerns.
15. Purchasers should coordinate initiatives with one another.
16. Purchasers who take lower cost options should negotiate mechanisms for employees to upgrade their health care coverage.

IV. ECONOMICS/PLANS

(Defined as entities with covered lives)

(The top five major recommendations appear in bold.)

1. **Health plans/insurers should fund the implementation of an infrastructure that facilitates an integrated data collection and feedback system (including practitioner, performance, quality, and safety data) using standardized information technology tools within and across plans.**
2. **Health plans/insurers should be held equally accountable with practitioners and providers and collaboratively work with downstream[3] entities to establish and enforce evidence-based quality and patient safety standards, policies, and programs.**
3. **Health plans/insurers should contract with practitioners, providers, and suppliers with a proven record of quality and patient safety.**
4. **Health plans/insurers should use and publicly report national measures of quality and patient safety.**
5. **Health plans/insurers should partner with patient quality and safety and physician organizations to develop a practitioner quality and safety measurement process.**
6. To increase accountability and better assure the delivery of safe, patient-centered care, health plans/insurers should include consumers at all levels of planning and program development, including governing boards and advisory committees.
7. Health plans/insurers should require evidence of continuing competence of affiliated practitioners and providers.

[3] Downstream entities are defined in the May 2001 OIG report entitled "Managed Care Organization Non-Reporting to the National Practitioner Data Bank: A Signal for Broader Concern" as hospitals, physician practice groups, and State licensing boards.

8. Health plans/insurers should create a unified, personalized medical record for each patient (member owned) to enhance patient safety.
9. Health plans/insurers should create partnerships that develop and utilize a single credentialing database for all practitioners.
10. Based on lessons learned that are both internal and external to health care, health plans/insurers should develop new infrastructures to decrease medical errors.
11. Health plans/insurers should establish the infrastructure necessary for chronic disease population management.
12. Health plans/insurers should promote consumer education regarding healthy lifestyle choices.
13. Health plans and insurers should increase comparability across plans and provide flexibility to consumers.
14. Health plans/insurers should focus on health and wellness by paying for select health and wellness activities and offering rewards and incentives for patient health improvements and healthy behavior.
15. Health plans/insurers should offer real-time online eligibility for patients linked with real-time online payment for practitioners and providers using quality and patient safety standards.
16. Health plans and insurers, regardless of type, should be held accountable for quality and patient safety.
17. Health plans/insurers should contractually require entities and practitioners to actively participate in a Statewide patient safety organized program.
18. Health plans/insurers should promote transparency of quality and safety variation to employers, purchasers, and patients.
19. Health plans/insurers should measure and provide incentives for entity and practitioner quality (including reporting).

V. PROFESSIONALISM

(The top six major recommendations appear in bold. Numbers five and six tied in ratings)

1. **Professional organizations and practitioners should advocate for the creation of a quality and patient safety certification for practitioners that: (1) requires mastery of evidence-based medicine (if passing an examination is part of the certification process, the examination should demonstrate an understanding of and the ability to use quality and patient safety data for improvement); (2) holds the practitioner accountable for lifelong learning to maintain competence and enhance professional development; and (3) requires periodic demonstration, throughout the practitioner's career, of competence in his/her specialty, knowledge and appropriate implementation of new technologies or procedures, and communication skills.**
2. **Practitioners should focus on and adopt strategies for patient-centered health care delivery, which include identifying risks, both active and latent, across the continuum of care (e.g., including handoffs and coordinated care with others).**

3. **Practitioners should: (1) communicate with their patients at the appropriate health literacy level on quality and patient safety-related issues; (2) educate patients about wellness and self-care, and acknowledge their efforts to improve behavior; (3) obtain patient-centered informed consent to disclose condition-specific risks, unanticipated adverse outcomes, and best practices; and (4) maintain this data in a centralized quality and patient safety condition repository that is available to other professionals.**
4. **Practitioners should promote a quality and patient safety culture and transparency through accountability for decisions, actions, and behavior, including meeting the intent and spirit of accreditation and regulatory quality and patient safety standards.**
5. **Professional organizations and practitioners should advocate for mandatory use of compatible electronic health record systems that include clinical decision support.**
6. **Professional organizations should help develop, endorse, and participate in the reporting of national quality and patient safety measures.**
7. Practitioners should practice and model sound communication and teamwork skills.
8. Health care professionals should report errors and near misses and be part of the solution and sharing of learning.
9. Practitioners should adhere to professional standards.
10. Professional associations should advocate for funding for the development and implementation of uniform electronic health records and information technology data sharing systems.
11. Professional associations should support statewide quality and patient safety by encouraging practitioners to actively participate in quality and patient safety organizations.
12. Practitioners are stakeholders that need to participate in the development and implementation of quality and patient safety standards.
13. Practitioners should create independent and valid methods of peer review.
14. Practitioners should practice evidence-based medicine.
15. Professional associations should create a reasonable conflict resolution model to use with practitioners and health plans/hospitals or other entities.
16. Professional associations should adopt standards and position statements that recognize the value of evidence-based practices and active participation in quality and patient safety improvement activities.

VI. HEALTH CARE DELIVERY INSTITUTIONS/SYSTEMS

(The top five major recommendations appear in bold.)

1. **Health care delivery institutions/systems that have in place formal credentialing and privileging systems should: (1) consider all areas of competency including quality and patient safety when hiring/contracting with practitioners; and (2) include processes for continuous evaluation of**

competencies to delivery quality and safe care.

2. **Health care delivery institutions/systems should make "safety first" an institutional priority throughout staff, starting with leadership.**
3. **Health care delivery institutions/systems should participate in the development and implementation of published national standards for quality and patient safety; identify and collect valid, reliable and meaningful indicators/measures of quality and patient safety; and make available user-friendly reports of how their entities meet these standards for improvement purposes.**
4. **Organizations such as the American Hospital Association and the Federation of Hospitals should advocate for Federal funding for electronic health record (EHR) systems and interconnected information technology (IT) systems.**
5. **Health care delivery institutions/systems should implement inter- and intra-organizational transparent IT infrastructures to support quality and patient safety, including adequate staff training and support and EHRs that include clinical decision support.**
6. Health care delivery institutions/systems should participate in State and Federal, mandatory and voluntary, patient safety and error and incident reporting programs that include a provision for reporting without fear of retribution.
7. Health care delivery institutions/systems should assign responsibility for episode of care coordination (continuity of care to, from, and between).
8. Health care delivery institutions/systems should apply and document the use of evidence-based medicine standards in all care processes.
9. Health care delivery institution/system associations should develop a process for publicly recognizing high-performing health care entities.
10. Health care delivery institutions/systems should expect, purchase, and reward the provision of safe, quality health care.
11. Health care delivery institutions/systems should develop infrastructures necessary to become highly reliable organizations.
12. Health care delivery institutions/systems should make timely use of appropriate research, such as rapid response teams, and implement proven technologies such as bar codes.
13. Health care delivery institutions/systems should encourage practitioners to openly and promptly inform patients' families when an error results in patient death or serious harm.
14. Health care delivery institutions/systems should develop checklists for high-risk procedures.
15. Health care delivery institutions/systems should involve consumers at all levels (including governance) in the oversight, development, and implementation of quality and patient safety programs.
16. Health care delivery institutions/systems should provide/procure the tools, education, and training for all aspects of patient safety for all levels of staffing positions.
17. Health care delivery institutions/systems should acknowledge their prime responsibility for quality and patient safety.

18. Health care delivery institutions/systems should allow sharing of quality outcome data on practitioners among organizations.

VII. CONSUMERS

(The top five major recommendations appear in bold.)

1. **Consumers should play an active role in their health care by: (1) being allowed to designate a health care advocate; (2) participating in disease self-management activities; (3) bringing potential or actual risks/errors to the attention of the appropriate person; (4) preparing for visits, asking questions, and planning for follow-up; (5) utilizing available data on quality and patient safety in making practitioner, system, and plan decisions; (6) utilizing tools for maintaining an up-to-date health history and list of current medications; and (7) disclosing to practitioner(s) conditions that could impact care (e.g., literacy and language issues and over-the-counter medications).**
2. **Consumers should encourage the development of a personal health records that are portable and accessible.**
3. **Consumers have a right to safe and quality health care services, and while they have responsibilities for adherence to medical recommendations, they should not be held primarily responsible for active, continual monitoring of the delivery of safe, quality services.**
4. **Consumers should take responsibility for their own lifestyle choices.**
5. **Consumers should demand government funding, development, and facilitation of a national framework for reporting quality and patient safety issues.**
6. Consumers should demand government funding, development, and facilitation of uniform electronic health record systems including interoperability.
7. Consumers should be included on health care entity boards and community advisory groups.
8. Patient participation in maintenance or improvement of health should be tied to reimbursement (i.e., the safe driver model).
9. Consumers should demand more and better evidence-based information from their employers, all levels of government, and their health care plan or insurer.

Appendix B

Crosswalk

STAKEHOLDER INVOLVEMENT

I. Government and Regulations #15: Federal government should develop a structure for and fund demonstration projects for consumer groups and health care professionals to work together to improve patient safety.

I. Government and Regulations #17: Federal and State governments should, in collaboration with stakeholders, consolidate and streamline patient safety measures from key agencies and organizations.

II. Accreditation and Certification Organizations #14: Accreditation and certification organizations should take a larger role in educating stakeholders (consumers, purchasers, etc.) about quality and patient safety.

III. Purchasers #8: Purchasers should create a multidisciplinary study group of stakeholders to promote a collaborative approach to purchasers' and providers' common goals for safe quality patient care.

III. Purchasers #11: Purchasers should recognize the value of including providers and practitioners in the development and implementation of initiatives to improve quality and patient safety.

III. Purchasers #12: Purchasers should work with health care and stakeholder organizations to develop and disseminate information on patient safety.

IV. Economics/plans #9: Health plans/insurers should create partnerships that develop and utilize a single credentialing database for all practitioners.

VI. Health Care Delivery Institutions/Systems #15: Health care delivery institutions/systems should involve consumers at all levels (including governance) in the oversight, development, and implementation of quality and patient safety programs.

VII. Consumers #7: Consumers should be included on health care entity boards and community advisory groups.

ACCOUNTABILITY

I. Government and Regulations #11: State governments should establish a minimal quality standard for practice (community specialty) that is self-reported and transparent.

II. Accreditation and Certification Organizations #9: Accreditation and certification organizations should collaborate on the development of common or complimentary standards relative to the measurement of quality and patient safety.

II. Accreditation and Certification Organizations #10: Accreditation and certification organizations should develop standards and measures that encourage health care entities to incorporate incentives for increasing health care quality and value.

III. Purchasers #6: Purchasers should include penalties for underperformance in the next generation of pay for performance contracts.

III. Purchasers #7: Purchasers should promote and pay for quality and patient safety sub-networks.

III Purchasers #13: Purchasers should provide report cards of health plans to employees and reward employees if they choose a health plan with a better track record.

III Purchasers #16: Purchasers who take lower cost options should negotiate mechanisms for employees to upgrade their health care coverage.

IV. Economics/plans #2: Health plans/insurers should be held equally accountable with practitioners and providers and collaboratively work with downstream entities to establish and enforce evidence-based quality and patient safety standards, policies, and programs[4].

IV. Economics/plans #4: Health plans/insurers should use and publicly report national measures of quality and patient safety.

IV. Economics/plans #5: Health plans/insurers should partner with patient quality and safety and physician organizations to develop a practitioner quality and safety measurement process.

IV. Economics/plans #6: To increase accountability and better assure the delivery of safe, patient-centered care, health plans/insurers should include consumers at all

[4] Downstream entities are defined in the May 2001 OIG report entitled "Managed Care Organization Non-Reporting to the National Practitioner Data Bank: A Signal for Broader Concern" as hospitals, physician practice groups, and State licensing boards.

levels of planning and program development, including governing boards and advisory committees.

IV. Economics/plans #14: Health plans/insurers should focus on health and wellness by paying for select health and wellness activities and offering rewards and incentives for patient health improvements and healthy behavior.

IV. Economics/plans #16: Health plans/insurers, regardless of type, should be held accountable for quality and patient safety.

IV. Economics/plans #17: Health plans/insurers should contractually require entities and practitioners to actively participate in a statewide patient safety organized program.

V. Professionalism #1: Professional organizations and practitioners should advocate for the creation of a quality and patient safety certification for practitioners that: (1) requires mastery of evidence-based medicine (if passing an examination is part of the certification process, the examination should demonstrate an understanding of and the ability to use quality and patient safety data for improvement); (2) holds the practitioner accountable for lifelong learning to maintain competence and enhanced professional development; and (3) requires periodic demonstration, throughout the practitioner's career, of competence in his or her specialty, knowledge and appropriate implementation of new technologies or procedures, and communication skills.

V. Professionalism #4: Practitioners should promote a quality and patient safety culture and transparency through accountability for decisions, actions, and behavior, including meeting the intent and spirit of accreditation and regulatory quality and patient safety standards.

V. Professionalism #9: Practitioners should adhere to professional standards.

V. Professionalism #12: Practitioners are stakeholders that need to participate in the development and implementation of quality and patient safety standards.

V. Professionalism #16: Professional associations should adopt standards and position statements that recognize the value of evidence-based practices and active participation in quality and patient safety improvement activities.

VI. Health Care Delivery Institutions/Systems #3: Health care delivery institutions/systems should participate in the development and implementation of published national standards for quality and patient safety, identify and collect valid, reliable and meaningful indicators/measures of quality and patient safety, and make available user-friendly reports of how their entities meet these standards for improvement purposes.

VI. Health Care Delivery Institutions/Systems #8: Health care delivery institutions/systems should apply and document the use of evidence-based medicine standards in all care processes.

VI Health Care Delivery Institutions/Systems #10: Health care delivery institutions/systems should expect, purchase, and reward the provision of safe, quality health care.

VII. Consumers #3: Consumers have a right to safe and quality health care services, and while they have responsibilities for adherence to medical recommendations, they should not be held primarily responsible for active, continual monitoring the delivery of safe, quality services.

VII. Consumer #8: Patient participation in maintenance or improvement of health should be tied to reimbursement (i.e., safe driver model).

CONTINUUM OF CARE

I. Government and Regulations #7: Federal and State governments should mandate that all plans offer the total range of health care coverage (e.g., including behavioral health).

II. Accreditation and Certification Organizations #17: Accreditation organizations should develop processes/standards to address issues of continuity of care.

V. Professionalism #2: Practitioners should focus on and adopt strategies for patient-centered health care delivery, which include identifying risks, both active and latent, across the continuum of care (e.g., including handoffs and coordinated care with others).

VI. Health Care Delivery Institutions/Systems #7: Health care delivery institutions/systems should assign responsibility for episode of care coordination (continuity of care to, from, and between).

INFRASTRUCTURES

IV. Economics/plans #10: Based on lessons learned that are both internal and external to health care, health plans/insurers should develop new infrastructures to decrease medical errors

IV. Economics/plans #11: Health plans/insurers should establish the infrastructure necessary for chronic disease population management.

VI. Health Care Delivery institutions/systems #11: Health care delivery institutions/systems should develop the infrastructure necessary to become highly reliable organizations.

TOOL AND MEASURES

ELECTRONIC HEALTH RECORDS

I. Government and Regulations #2: The Federal government should adequately fund the development of uniform electronic health records (EHR) and claims systems, including setting standards and proposing an implementation timeline with interoperability.

V. Professionalism #10: Professional associations should advocate for funding for the development and implementation of uniform electronic health records and information technology data sharing systems.

VI. Health Care Delivery Institutions/Systems #4: Organizations such as the American Hospital Association and the Federation of Hospitals should advocate for Federal funding for electronic health record (EHR) systems and interconnected information technology (IT) systems.

VII. Consumer #6: Consumers should demand government funding, development, and facilitation of uniform EHR systems including interoperability.

CLINICAL DECISION SUPPORT

V. Professionalism #5: Professional organizations and practitioners should advocate for mandatory use of compatible electronic health record systems that include clinical decision support.

VI. Health Care Delivery Institutions/Systems #5: Health care delivery institutions/systems should implement inter- and intra-organizational transparent information technology infrastructures to support quality and patient safety, including adequate staff training and support and electronic health care records that include clinical decision support.

TAXONOMIES

I. Government and Regulations #1: The Federal government should facilitate and fund the development of a framework, taxonomy and measurement tools for quality and patient safety.

II. Accreditation and Certification Organizations #12: Accreditation and certification organizations should develop a national framework, taxonomy and measurement tools for quality and patient safety.

III. Purchasers #4: Purchasers should educate employees to become wise consumers, and should create and use a taxonomy that designates quality and safety in educational tools.

REPORTING

I. Government and Regulations #3: As more States set up safety related reporting systems (mandatory and voluntary), Federal government should develop national standards governing the reporting of information; create a Federal repository for the data; guarantee a safe harbor for practitioners reporting the data; and make the data publicly available.

I. Government and Regulations #20: The Federal Government should include a broader range of practitioners (e.g., nurses, pharmacists) in the collection of data on adverse events and increase the accessibility of the data.

II. Accreditation and Certification Organizations #3: Best practice models should be developed for accrediting and certifying organizations relative to quality and patient safety, including a system to evaluate and improve both voluntary and mandatory reporting and research to continually improve quality and patient safety tools.

II. Accreditation and Certification Organizations #5: Accreditation and certification organizations should work with all stakeholders to reduce the burden of redundant reporting.

II. Accreditation and Certification Organizations #6: Accreditation organizations should share data with each other and the public (e.g., they should no longer allow health plans to opt out of reporting quality scores).

II. Accreditation and Certification Organizations #8: Accreditation and certification organizations should develop standards consistent with a just culture to promote non-punitive, confidential reporting of harm producing events and issues with practitioner competency.

II. Accreditation and Certification Organizations #11: Accreditation organizations should ensure that health care entities comply with the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank reporting requirements.

III. Purchasers #5: Purchasers should ensure that payments include the cost of quality and patient safety reporting.

IV. Economics/plans #19: Health plans/insurers should measure and provide incentives for entity and practitioner quality (includes reporting).

V. Professionalism #6: Professional organizations should help develop, endorse, and participate in the reporting of national quality and patient safety measures.

V. Professionalism #8: Health care professionals should report errors and near misses and be part of the solution and sharing of learning.

VI. Health Care Delivery Institutions/Systems #6: Health care delivery institutions/systems should participate in State and Federal, mandatory and voluntary, patient safety and error and incident reporting programs that include a provision for reporting without fear of retribution.

VII. Consumers #5: Consumers should demand government funding, development, and facilitation of a national framework for reporting quality and patient safety issues.

CENTRALIZE DATA

I. Government and Regulations #3: As more States set up safety related reporting systems (mandatory and voluntary), Federal government should develop national standards governing the reporting of information; create a Federal repository for the data; guarantee a safe harbor for practitioners reporting the data; and make the data publicly available.

I. Government and Regulations #19: Federal government should develop a national practitioner credentialing clearinghouse.

I. Government and Regulations #21: Federal government should increase the portability of patient information through the creation of a national patient health registry, which would be available to practitioners and health care entities.

II. Accreditation and Certification Organizations #11: Accreditation organizations should ensure that health care entities comply with the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank reporting requirements.

IV. Economics/plans #9: Health plans/insurers should create partnerships that develop and utilize a single credentialing database for all practitioners.

V. Professionalism #3: Practitioners should: (1) communicate with their patients at the appropriate health literacy level on quality and patient safety-related issues; (2) educate patients about wellness and self-care, and acknowledge their efforts to improve behavior; (3) obtain patient-centered informed consent to disclose condition-specific risks, unanticipated adverse outcomes, and best practices; and (4) maintain this data in a centralized quality and patient safety condition repository that is available to other professionals.

VI. Health Care Delivery Institutions/Systems #18: Health care delivery institutions/systems should allow sharing of quality outcome data on practitioners among organizations.

CONTINUED COMPETENCE

I. Government and Regulations #4: State governments should incorporate continued competence mandates into State licensing requirements.

I. Government and Regulations #6: Federal government should promulgate and enforce rules and regulations that are consistent with a just culture and contain a clear directive to address competency issues.

II. Accreditation and Certification Organizations #7: Accreditation and certification organizations should incorporate real time data elements into a system that measures continued competence (e.g., continuous reporting for electronic health records).

IV. Economics/plans #7: Health plans/insurers should require evidence of continuing competence of affiliated practitioners and providers.

V. Professionalism #1: Professional organizations and practitioners should advocate for the creation of a quality and patient safety certification for practitioners that: (1) requires mastery of evidence-based medicine (if passing an examination is part of the certification process, the examination should demonstrate an understanding of and the ability to use quality and patient safety data for improvement); (2) holds the practitioner accountable for lifelong learning to maintain competence and enhance professional development; and (3) requires periodic demonstration, throughout the practitioner's career, of competence in his/her specialty, knowledge and appropriate implementation of new technologies or procedures, and communication skills.

V. Professionalism #7: Practitioners should practice and model sound communication and teamwork skills.

VI. Health Care Delivery Institutions/Systems #1: Health care delivery institutions/systems that have in place formal credentialing and privileging systems should: (1) consider all areas of competency including quality and patient safety when hiring/contracting with practitioners; and (2) include processes for continuous evaluation of competencies to delivery quality and safe care.

TRANSPARENCY

I. Government and Regulations #14: Federal, State and local governments should promote transparency in a quality and patient safety culture.

I. Government and Regulations #18: Federal, State and local governments should increase the transparency of licensing investigatory information from State to State.

IV. Economics/plans #18: Health plans/insurers should promote transparency of quality and safety variation to employers, purchasers, and patients.

V. Professionalism #4: Practitioners should promote a quality and patient safety culture and transparency through accountability for decisions, actions, and behavior, including meeting the intent and spirit of accreditation and regulatory quality and patient safety standards.

CONSUMER EDUCATION/INFORMATION

I. Government and Regulations #12: State and local governments should create a uniform, user-friendly and meaningful approach to providing consumer information about quality and patient safety.

III. Purchasers #4: Purchasers should educate employees to become wise consumers, and should create and use a taxonomy that designates quality and safety in educational tools.

III. Purchasers #12: Purchasers should work with health care and stakeholder organizations to develop and disseminate information on patient safety.

IV. Economics/plans #12: Health plans/insurers should promote consumer education regarding healthy lifestyle choices.

VII. Consumers #9: Consumers should demand more and better evidence-based information from their employers, all levels of government, and their health care plan or insurer.

RESEARCH

I. Government and Regulations #5: The Federal government should support research to develop and improve quality and patient safety management tools available to organizations.

II. Accreditation and Certification Organizations #3: Best practice models should be developed for accrediting and certifying organizations relative to quality and patient safety, including a system to evaluate and improve both voluntary and mandatory reporting and research to continually improve quality and patient safety tools.

VI Health Care Delivery Institutions/Systems #12: Health care delivery institutions/systems should make timely use of appropriate research, such as rapid response teams, and implement proven technologies such as bar codes.

Appendix C

GLOSSARY

Downstream Entities: Hospitals, physician practice groups, and State licensing boards as defined in the May 2001 OIG report entitled "Managed Care Organization Non-Reporting to the National Practitioner Data Bank: A Signal for Broader Concern"

Economics/Plans: Entities with covered lives.

Evidenced Based Medicine: The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

Interoperability: The ability of software and hardware on different machines to share data.

Just Culture: The balance of learning from mistakes and accountability for error in a specific environment.

Practitioner: An individual who is licensed or otherwise authorized by the State (or territory) to provide health care services.

Provider: Any health care entity that, directly or through contracts, provides health services.

Purchasers: Companies and other public and private organizations that purchase health care benefits for their employees.

Quality and Patient Safety Culture: The product of individual and group values, attitudes, perceptions, competencies and patterns of behaviors that determine the commitment to and the style and proficiency of an organization's health and quality and safety management. Organizations with a positive quality and safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of quality and safety and by confidence in the efficacy of preventive measure.

Supplier: A provider of medical and other health care services or any individual or entity, other than a provider, who furnishes, whether directly or indirectly, or provides access to, health care services, supplies, items, or ancillary services (e.g., durable medical equipment suppliers, pharmaceutical suppliers).

Transparency: Publicly available, clear and understandable.

Appendix D

Participants

The views expressed during the workshop were those of the participants and not necessarily those of the organizations they represent.

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